

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH



FULL SERVICE PARTNERSHIP APPEAL FORM

DATE: _____ Child TAY Adult Older Adult

Agency: _____ Contact Person: _____

Phone: _____ Fax: _____ E-mail: _____

CLIENT LAST NAME: _____ CLIENT FIRST NAME: _____ DOB: _____ SSN: _____ DMH IS#: _____

Reason for Appeal (Check ONE Only):

- DMH Impact Unit has referred an eligible client to our agency that we decline to enroll.
Our agency has requested authorization to enroll a client and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to enroll.
Our agency has requested authorization to disenroll a client and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to disenroll.
Our agency has requested authorization to transfer a client between FSP programs and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to transfer.

Explain Reason for Appeal:

Empty box for explaining the reason for appeal.

Fax completed Appeal Form and copy of denied request to appropriate Service Area District Chief.

TO BE COMPLETED BY SERVICE AREA DISTRICT CHIEF

District Chief Name: _____ Service Area: _____

Phone: () _____ Fax: () _____

DISPOSITION: APPEAL APPROVED APPEAL DENIED

Explain Reason for Decision: _____

Service Area District Chief Signature: _____ Date: _____ Countywide District Chief Signature: _____ Date: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.